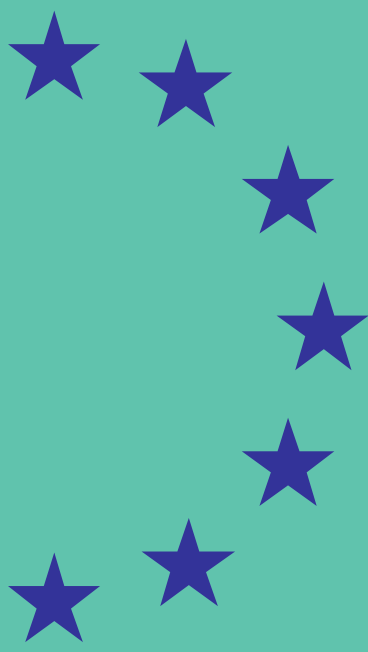




# Italy

## Health Care & Long-Term Care Systems



An excerpt from

**the Joint Report on Health Care  
and Long-Term Care Systems  
& Fiscal Sustainability,**

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Country Documents - 2019 Update

# Italy

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## Health care systems

From: *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability*, prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group), Country Documents – 2019 Update

## 2.15. ITALY

### General context: Expenditure, fiscal sustainability and demographic trends

*General country statistics: GDP, GDP per capita; population*

GDP per capita, 26,077 PPS in 2015, is slightly under the EU average for the same year (29,610 PPS) slightly up from 25,300 in 2014. Population, recorded at 60.8 million in 2015, is projected to decrease to 54.9 million in 2070, which at -9.6% represents a growth rate that is more than 11 pps lower than the average for the EU (2.0 % over the same period).

*Total and public expenditure on health as % of GDP, per capita PPP, public expenditure as % of total government expenditure. Recent trends and vs. EU average*

Total (public plus private) expenditure on health as a percentage of GDP (9.3% in 2015) is below the EU average <sup>(206)</sup> (10.2% in the same year). It has increased from 8.7% in 2005. Public expenditure on health as a percentage of GDP is also slightly below the EU average (7.0% vs. 8.0 % in 2015), up from 6.8% in 2005. Total (2,495 PPS) and public (1,887 PPS in 2015) per capita expenditure were below the EU average (3,305 PPS and 2,609 PPS in 2015), having increased since 2005 (2,219 PPS and 1,732 PPS), but with moderate changes in the second part of the decade. Looking at health care without long-term care <sup>(207)</sup> reveals a similar picture, with spending below the EU average but with a smaller gap (6.3% vs 6.8% in 2015).

The significant slowdown of the increase in the public health care expenditure has been achieved due to the governance regulations and procedures implemented in the last years, namely the Health Pact between State and Regions, the monitoring of the fulfilment of the budget objectives and the activation of the Deficit Reduction Plan procedure for those regions not complying with the agreed budget rules. As a result, public health care expenditure has grown by an annual average of

<sup>(206)</sup> The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units or units of staff where relevant. The EU average for each year is based on all the available information in each year.

<sup>(207)</sup> To derive this figure, the aggregate HC.3 is subtracted from total health spending.

0.9% in nominal terms over the period 2007-2016, against the 7.1% of the period 2000-2006 <sup>(208)</sup>.

*Expenditure projections and fiscal sustainability*

As a result of ageing, health care expenditure is projected to increase by 0.7 pps of GDP until 2070 (below the average change in the EU of 0.9 pps) <sup>(209)</sup>. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.1 pps of GDP from now until 2070 (EU: 1.6).

Medium and long term sustainability risks, which are classified as high for Italy, mainly derive from the high debt-to-GDP ratio and are only partly linked to health care expenditure and the projected cost of ageing <sup>(210)</sup>.

*Health status and disability (life expectancy, healthy life years, mortality, infant mortality)*

Life expectancy at birth (84.9 years for women and 80.3 years for men in 2015) is above the EU average (83.3 and 77.9 years in 2015). Healthy life years at birth for women and for men (62.7 and 62.6 respectively in 2015) are very close to the EU average for the same year (63.3 for females and 62.6 for males).

### System characteristics

*System financing: taxed-based or insurance-based*

A regionally based National Health Service (NHS), with a division of responsibilities between the central government and the regional governments (set by the 2001 Constitutional

<sup>(208)</sup> Ministero dell'economia e delle finanze – RGS (2017), *Il monitoraggio del sistema sanitario*, Report no.4. <http://www.rgs.mef.gov.it/Documenti/VERSIONE-I/Attivit-i/Spesa-soci/Attivit-monitoraggio-RGS/2017/IMDSS-RS2017.pdf>.

<sup>(209)</sup> I.e. considering the "reference scenario" of the projections (see the 2018 Ageing Report: [https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070\\_en](https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en)).

<sup>(210)</sup> European Commission, *Fiscal Sustainability Report* (2018) [https://ec.europa.eu/info/sites/info/files/economy-finance/ip094\\_en\\_vol\\_2.pdf](https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf).

Amendment), and funded mainly by taxation, provides full coverage of resident population <sup>(211)</sup>.

Starting from 2013, a new mechanism has been set for the distribution of financial resources among regions, according to the procedure envisaged in legislative decree 68/2011, which may be summarised as follows:

1. each year, the total amount of resources addressed to the financing of health system (according to the evolution of macroeconomic variables and budget constraint) is defined (so called "fabbisogno nazionale standard");
2. five benchmark regions are identified, among regions which: a) have guaranteed the delivery of health services efficiently and appropriately ensuring, at the same time, a budget balance position; b) have fulfilled the achievements ("Adempimenti") foreseen by law, according to the assessment of the relevant Committee (so-called "Tavolo degli Adempimenti"); c) have reached a high score in health quality ranking, according to the set of indicators envisaged in the Health Pact;
3. three regions out of the 5 benchmark ones are selected by the Conference of regions, being fixed the top ranked region;
4. the average regional standard costs are computed on the basis of the actual costs of the three reference regions;
5. standard costs are applied to the regional population, weighted with regional age structure;
6. the resulting distribution is applied to the *fabbisogno nazionale standard*, obtaining the *fabbisogno sanitario* of each region ("*fabbisogno regionale standard*").

The financial coverage of the regional *fabbisogno sanitario* is guaranteed through a mix of financial resources:

1. the regional tax on production activities (IRAP);
2. the surcharge on personal income tax;
3. revenues of the ASL/AO (Local Health Bodies/Hospital Bodies - *Aziende Sanitarie Locali/Aziende Ospedaliere*) from either sale of services or fees paid by citizens (so-called "tickets");
4. as for Regions with ordinary institutional status (*regioni a statuto ordinario*), a share of VAT revenue is granted to cover the difference between their *fabbisogno sanitario* and the resources obtained through the financial channels under points a)-c);
5. as for Regions with special institutional status (*regioni a statuto speciale*), the quota of their *fabbisogno sanitario* not covered by the financial channels under points a)-c) is to be financed through their own resources (additional contribution) <sup>(212)</sup>.

Regions are required to ensure a budget balance position. If they fail to comply with this requirement, a set of automatic measures is foreseen in order to restore the budget balance position (mainly the increase of regional taxes). In case of a deficit exceeding the 5% threshold (computed as a ratio between the value of regional deficit in nominal terms and the financial resources assigned to regions to finance health expenditure), regions are obliged to present a 'Deficit Reduction Plan' (*Piano di Rientro*). The latter has a time horizon of three years and lays down all the necessary measures to be taken by the region concerned to achieve the budgetary balance.

#### *Revenue collection mechanism (tax/social security contributions/premium)*

In 2015, 75.6% of total health expenditure funding came from earmarked public sources, including regional tax on production activities (corporation tax on the value added of companies and on the salaries of public sector workers - IRAP), regional

<sup>(211)</sup>Including foreign citizens, and their dependent relatives, who are in one of the following positions: a) employed; b) enrolled in the employment lists; c) had applied for a renewal of the permit of stay. As for dispositions concerning non- EU citizens, see law 40/1998, articles 32-34.

<sup>(212)</sup>For region Sicily only, this additional contribution accounts for at maximum 49.11% of its *fabbisogno sanitario*. The remaining part is financed by the National Health Fund (*Fondo Sanitario Nazionale*).

surcharge on income tax and a share of VAT revenue (see §. 1).

*Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions*

According to the organisational setting of the Italian Health Care System, the Ministry of Health, in agreement with the Ministry of Economy and Finance, defines general objectives and national policy priorities, as well as the basic levels of health care treatments which are provided for free over the national territory (so called *Livelli Essenziali di Assistenza-LEA*); regions are in charge with planning, coordinating and providing health services (including primary, specialist outpatient and hospital care, health promotion, disease prevention and rehabilitation, long-term nursing and psychiatric care) for their residents. They have large autonomy in the way they organise care delivery, within the general framework designed at national level. The funds to be allocated to each type of care are somewhat determined by both the central government and regions.

A Committee (so-called *Comitato LEA*) is in charge of monitoring the provision of LEAs in each region; the Committee is composed of representatives of the ministries concerned (Health and Economy and Finance), the Department of Regional Affairs (within the Presidency of the Council of Ministers) and Regions<sup>(213)</sup>.

Regions may choose to provide extra LEA benefits, and some do, but the relative costs should be covered through their own financial resources.

As foreseen by Law 208/2015, a new Decree regulating the LEA was issued, in January 2017, in replacement of the previous one adopted in 2001. The principal novelties introduced by the decree are as follows:

- health provisions that were already included in the LEA have been better detailed;

<sup>(213)</sup> Such a Committee was first established in 2005, according to article 9 of the Health Pact of 23rd March 2005.

- out of date health provisions have been eliminated and replaced with others more technologically advanced;
- the lists of chronic and invalidating diseases which give right to the exemption from co-payments have been updated;
- new compulsory vaccines have been foreseen.

#### *Coverage (population)*

Health services are provided for free to all citizens; however, a fee (co-payment) may be requested for the provision of some health services (e.g. specialist health services) depending on income and age requirements.

#### *Treatment options, covered health services*

Primary care and hospital inpatient care are free at the point of use. Outpatient specialist consultations that follow a referral from a general practitioner (GP - family doctor), diagnostic procedures involve a small fee as do pharmaceuticals prescribed by a physician in those regions who have chosen to use a fee. Unwarranted visits to emergency departments also involve a fee. Dental care is guaranteed for specific groups of the populations (children, vulnerable groups such as disabled, people with HIV and those with rare diseases) and in emergency cases, while others purchase dental care are out-of-pocket. Eyeglasses and contact lenses and dental prostheses are not funded or provided by regions. Patients visiting a physician without a referral or buying over-the-counter medicines have to pay for the full cost of care out of their pockets. Children below six, and elderly (65+) individuals with an income below a certain threshold, pregnant women and people with certain medical conditions are exempted from cost-sharing. According to the OECD (2010) 15.6% of the population buys duplicative private insurance (to cover for the same services covered by public provision/ funding).

Waiting times and lists for specialist consultation and hospital surgery are considered long by the population and there are important regional variations in the waiting time, which are seen as a problem in Italy. To reduce waiting times, the 28<sup>th</sup> of October 2010 the Agreement between the

Government, the Regions and Autonomous Provinces on the Government National Plan of waiting lists (PNGLA) for 2010-2012 was signed<sup>(214)</sup>. In addition, patients are allowed to obtain hospital care in other regions and there is a system of interregional compensation whereby regions paid for the patients they send away and receive the payments of those who come into the region to receive treatment. The interregional mobility is directly related to the right of citizens to choose health care treatments, for example by accessing high specialised health structures located out of their own region.

#### *Role of private insurance and out of pocket payments*

In 2015, 24.4% of total (public and private) health care expenditure came from out-of-pocket payments and private insurance altogether. The remaining 75.6% was publicly funded. The share of out-of-pocket payments in Italy is currently above EU average (15.9% in 2015).

#### *Types of providers, referral systems and patient choice*

As the responsibility for care delivery has been delegated to the regions, there may be differences in the way the various types of care are organised/delivered.

In general, health care services are provided for free through public providers (ASLs, public hospitals, university public hospitals) as well as private accredited providers. Health services can be delivered also by private non-accredited providers but the relative costs are fully charged on the users.

Primary care is provided by independent general practitioners (GPs) and paediatricians acting on the basis of a contract with the NHS, and running their activities in single practices or in joint practices (for which a financial incentive is provided).

Outpatient specialist care is provided by specialist doctors in outpatient departments in hospitals as well as in private ambulatories (both accredited

and not accredited). A decree of Ministry of health (issued according to Decree law 78/2015, converted into Law 125/2015) has laid down supplying conditions and appropriateness indications, which doctors must report in their prescriptions. In case doctors do not comply with this obligation, the additional part of their compensation is reduced and any specialist care provided in contrast with the decree is charged to patients.

Day case and inpatient care also take part in hospitals. Provision has traditionally been public but currently health services are provided also by private providers. According to the OECD (2012), about 68% of all acute hospital beds are public, 4% are private not-for profit and 28% is private for profit. Some public hospitals (*Aziende Ospedaliere*) have also been given financial and technical autonomy (contracting with the ASLs), while others remain under the direct management of the ASLs.

The ASLs oversee also health promotion, disease prevention and occupational diseases activities.

The number of practising physicians per 100 000 inhabitants (384 in 2015) is above the EU average (344 in 2015). The number of GPs per 100 000 inhabitants (74 in 2015) is broadly in line with the EU average for the same year (78). The number of nurses per 100 000 inhabitants (544 in 2015) is well below the EU average of 833.

The authorities' efforts to encourage the use of primary care vis-à-vis specialist and hospital care include compulsory registration with a GP and a compulsory referral system from primary to secondary care (i.e. GPs act like gatekeepers to specialist and hospital care), while allowing patient choice of GP, specialist and hospital<sup>(215)</sup>. The coverage of primary care services in health centres is guaranteed over 24 hours, through the primary care out of hours (so called *guardia medica*). Over time there has been a strong emphasis on primary care as the first point of access to care, emphasis that is to continue to ensure quality and efficiency of care. Patient satisfaction with primary care GPs and paediatricians is high. Moreover, the authorities have been introducing a number of ICT

<sup>(214)</sup> For further information, see: [http://www.salute.gov.it/portale/temi/p2\\_5.jsp?area=qualita&menu=liste](http://www.salute.gov.it/portale/temi/p2_5.jsp?area=qualita&menu=liste).

<sup>(215)</sup> Indeed, according to the OECD, the level of choice of provider and gatekeeping in Italy both score of 6 out of 6.

and e-health solutions to allow for nationwide electronic exchange of medical data (including patient electronic medical records and patient e-card) to support care coordination, reduce medical errors and increase cost-efficiency as well as monitoring activity and consumption.

The number of acute care beds per 100 000 inhabitants (264 in 2015) is below the EU average (402 in 2015). In line with the EU trend, the number of acute beds in Italy has been decreasing over the last decade (344 in 2005), as a result of the policies run over the last years aimed at reducing the rate of acute beds towards the standard levels set by the current legislation <sup>(216)</sup>. In some areas there may be a shortage of follow-up/long-term care beds/ facilities which might create bed-blockages in acute care. It is regional government to plan for the number of hospitals, the provision of specific specialised services.

#### *Pricing, purchasing and contracting of healthcare services and remuneration mechanisms*

Primary care physicians are paid on a capitation basis, while outpatient and inpatient specialists acting in public structures are paid by a salary. The pay scale is determined at national level. Primary care physicians appear to be eligible to receive bonuses regarding preventive care or disease management activities <sup>(217)</sup>. Private sector doctors are paid a fee-for-service.

Hospitals remuneration is on a payment per case basis using DRGs <sup>(218)</sup>. Hospital remuneration

<sup>(216)</sup> According to law decree 95/2012, the standard rate for acute care beds is set at 300 per 100 000 inhabitants.

<sup>(217)</sup> It is foreseen by article 8 of the National General Agreement (Accordo nazionale collettivo) concerning the discipline of GP.

<sup>(218)</sup> The OECD score for remuneration incentives to raise the volume of care in Italy is a bit more than 3 out of 6 as a result of the use of activity related payment in hospital remuneration though not in other areas. The OECD overall efficiency score for Italy is slightly higher than its group average (about 1.8 years potential gain to be made through greater efficiency in the sector compared to the group average of 2.6 years) and above the OECD average (2.3 years). There are nevertheless areas for improvement including: continue to improve efficiency in the hospital sector notably through the publication of comparable information on activity and quality and/or through an element of activity related payment of physicians; increasing consistency in the allocation of resources across levels of government.

methods are defined at central level with the DRG weights and other service rates negotiated at regional level.

When looking at hospital activity, inpatient discharges per 100 inhabitants are below the EU average (11 vs. 16 in 2015). Day case discharges have almost halved through the decade (contrary to the EU trend which has seen a steady increase <sup>(219)</sup>), and they are well below the EU average (7635 in 2015). On the contrary, overall inpatient hospital length of stay (7.8 days in 2015) <sup>(220)</sup> is in line with the EU average, though slightly above (7.6 days).

#### *The market for pharmaceutical products*

Total (1.6%) and public (1.0%) expenditure on pharmaceuticals as a percentage of GDP was broadly in line with the EU average (respectively 1.4% and 1%) in 2015. Total (17.9%) and public (15.0%) pharmaceutical expenditure as a percentage of total current health expenditure is respectively above and slightly below the EU average (14.6% and 12.7% in 2015). The policy priority is to keep under control the dynamics of public pharmaceutical expenditure by fixing appropriate ceilings as a share of the financing level of the National Health Service (*Servizio Sanitario Nazionale* - SSN) contributed by the State <sup>(221)</sup>.

The authorities have implemented a number of policies to control expenditure on pharmaceuticals, based on (i) limits to expenditure dynamics and (ii) control of pharmaceuticals prices. Expenditure rules on pharmaceutical products exist since 2001; however, since 2008, a new rule was introduced, foreseeing thresholds for pharmaceutical products supplied by pharmacies or, directly, by the ASLs. The rule established two expenditure ceilings for pharmaceutical products (including patient co-payments) expressed as a percentage of the financing level for the National Health Service

<sup>(219)</sup> This refers to the aggregate EU-28.

<sup>(220)</sup> Eurostat, Last update 10.07.15, In-patient average length of stay (in days), Services of curative care.

<sup>(221)</sup> For the details, see section 6.

contributed by the State. Starting from 2017, the thresholds are set as follows <sup>(222)</sup>:

- 7.96% for pharmaceutical products supplied by pharmacies;
- 6.89% for pharmaceutical products directly supplied by the ASLs and hospitals;

The expenditure ceilings must be respected both at regional and national levels.

As for the latter expenditure item, since 2008 an automatic procedure (so-called pay-back) is in place to compensate for possible overruns.

Concerning price control policies, the initial price of a new pharmaceutical product is based on clinical performance, economic evaluation, on the cost of existing treatments. There are controlled price updates. Price setting involves important negotiations between the Italian Pharmaceutical Agency (*Agenzia Italiana del Farmaco - AIFA*) and the pharmaceutical companies and negotiations take into consideration the social relevance of the disease, the effect of the medicines, the expected utilisation and financial impact, prices in other countries, prices of similar products in Italy. Discounts, payback and price freezes and cuts are some of the mechanisms used to directly control expenditure. There is a positive list of reimbursed products which is based on health technology assessment information/economic evaluation. Reference pricing for reimbursement purposes is also applied. For medicines for which generics are available the reimbursement level is set at the lowest price of the drugs in a group (defined as drugs with same active ingredient, bioequivalent form and therapeutic indications), and the cheapest price must be at least 20% lower than the originator product. For those without generics, the reimbursement level of a new drug is based on a sort of average cost of a defined group of medicines that are related but slightly different chemically.

Authorities promote rational prescribing of physicians through treatment and prescription

<sup>(222)</sup> Before 2017, the threshold were, respectively, 11.35%, and 3.5%, being the pharmaceutical products supplied by the ASLs included in the former instead of in the latter.

guidelines complemented with education and information campaigns on the prescription and use of medicines and the monitoring of prescribing behaviour (by regions and ASLs). GPs receive some kind of feedback on their prescription patterns. Authorities also pursue information and education campaigns directed at patients and some regions have introduced a small fee for either pack or receipt to make patients more sensitive to the cost of medicines and encourage a rational use of medicines on the patients' side. There is an explicit generics policy. Generic sales' targets are set by the Italian Pharmaceutical Agency. Generic substitution takes place i.e. pharmacies are obliged to offer the generic medicine when available. If patients refuse a generic, they will have to pay the difference between the reimbursement price of the branded drug and the pharmacy retail price of the cheapest available generic. Generics are exempted from the mandatory discount of pharmacies to the NHS so as to encourage pharmacies to hold and sell generics.

In order to monitor and keep under control the dynamics of pharmaceutical expenditure and GPs' prescriptions, a comprehensive information system called "*Sistema Tessera sanitaria*" has been implemented.

#### *Use of Health Technology Assessments and cost-benefit analysis*

Health Technology Assessment is undertaken at various levels although there is no national structure responsible for conducting, promoting, coordinating or financing HTA. There are clinical guidelines for medical interventions and medicines established through the National Programme on Clinical Guidelines.

#### *E-health (e-prescription, e-medical records)*

Starting from 2003, the "*Tessera Sanitaria*" information system (herehence "TS") has been gradually implemented under the supervision and management of the Ministry of Economy and Finance - Department of General Accounts. In 2009, such a system was fully implemented in all regions and since then it has been regularly utilised for the monitoring of the full procedure for pharmaceutical and specialist care provisions, from the prescription to the delivery. Besides, through a set of performance indicators, the *Tessera*



*Sanitaria* system allows to make cross-regional comparative analysis on the efficiency and appropriateness of prescriptions.

Since 2013, the *TS* has also been utilised for the gradual implementation of the electronic medical prescription (*ricetta elettronica*) over the entire national territory, in line with the programme of the Italian Digital Agenda (*Agenda Digitale Italiana*) which foresees the full dematerialisation of medical prescriptions. In this regards, the *TS* has implemented a technological infrastructure for electronic interconnection with doctors, pharmacies, hospitals and other public health body, or private health body accredited by the National Health System <sup>(223)</sup>.

Since 2015, the *TS* also allows patients to check on-line their own private expenses on pharmaceutical and specialist care before they are submitted to the Fiscal Agency (*Agenzia delle entrate*) for the pre-filled income tax statement (*730-precompilato*). More recently, based on the Budget law for 2016, such electronic procedures have further strengthen in order to allow all patients to access and check on-line their health expenses all over the year regardless the transmission to the Fiscal Agency.

Finally, the implementation of the patient's electronic health record (*Fascicolo Sanitario Elettronico*), that was foreseen by law decree 179/2012, article 12, has been sped up through the involvement of the *TS*. In fact, the Budget Law for 2017 (Law 232/2016) assigned to the *TS* the task of creating the interoperability system (interconnection amongst regions) and the subsidiarity system (interconnection amongst health bodies within a region), for those regions still lacking of it. The directorial decree regulating both electronic systems was issued in August 2017 and, to date, the activities involved are nearing completion.

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<sup>(223)</sup> All this further strengthens the accuracy and timeliness in checking prescription appropriateness and requirements for co-payment exemptions. In 2015, about 350 million of dematerialised prescriptions were issued. Thanks to the e-prescription system, since 1st March 2016 the validity of prescriptions has been extended also to regions other than that of residence.

#### *Health and health-system information and reporting mechanisms*

Following a pilot period, a comprehensive information and monitoring system (National Healthcare Information System) - using 130 indicators and covering population health status, budgetary and economic efficiency, organisation climate and staff satisfaction, patient satisfaction, performance indicators (appropriateness, quality) and effectiveness in reaching regional targets - is now fully operational. A comprehensive set of indicators has been introduced by the Health Pact 2010-2012, for evaluating the performance of regional health services.

Several regions have adopted the system which uses standard codes. As a result, Italy will be able to gather extensive information at regional and sub-regional levels, which is publicly available on a website allowing for public comparisons. Such a system, allows regions to identify good practices as well as areas for improvement. Physicians are being monitored in terms of their activity and compliance with guidelines as well as their prescription behaviour. They receive feedback on their prescription patterns.

#### *Health promotion and disease prevention policies*

The central Government through the Ministry of Health sets and monitors public health priorities in terms of process, outcomes and the reduction of health inequalities. There are some risk factors that can translate into an important burden of disease and financial costs. The latest National Health plan lists a number of priority areas for health promotion and disease prevention which is proposed as good practice across the regions. Health promotion and disease prevention activities have not historically received the same emphasis as in other countries in the EU, as seen by its pattern of expenditure and some indicators. However, in 2015, public and total expenditure on prevention and public health services as a % of GDP are in line with the EU average (0.3% and 0.4% vs. 0.3% and 0.3% for the EU average in 2015), after a decade of consistently being markedly lower than average. Public and total expenditure on prevention and public health services as a % of current health expenditure (public and total, respectively) are currently both

above the EU average (4.7% vs. 3.2% and 4.0% vs. 3.2% in 2015).

#### *Transparency and corruption*

In order to guarantee the full accountability and monitoring of health sector, Italy has implemented an integrated governance framework.

Health expenditure trends are analysed on a quarterly and yearly basis, relating on a set of standardised economic accounts, mainly based on a profit and losses account and a balance sheet account. These accounts are filled at the regional level and single public provider of health services, on the basis of harmonised recording criteria.

A dedicated committee (named “*Tavolo degli Adempimenti*”) is in charge with the analysis of expenditure trend, the verification of the budget balance position and the fulfilment of the other requirements envisaged in the legislation.

A bonus (equal to the 3% of the regional share of national health fund) is granted to regions conditionally to a positive evaluation by the *Tavolo degli Adempimenti* about the fulfilment of all the requirements (and, firstly, the budget balance position) envisaged in the legislation.

#### **Recently legislated and/or planned policy reform**

In July 2014, a new Health Pact was signed between central government and regions. The main issues regulated by the Pact were as follows:

- the financial framework, i.e. the national level of public resources for the financing of the LEA (fabbisogno nazionale standard) for each of the years 2014-2016;
- a procedure for the revision of the current basic healthcare levels (LEA), which was subsequently adopted by a pertinent decree issued in January 2017 (see above);
- a strengthening of monitoring activity, through an increased role of the National Agency for regional Health Services (Agenzia Nazionale per i Servizi Sanitari Regionali, AGENAS) in

evaluating the quality of regional health services.

Furthermore, the budget law for 2016, introduced a Deficit Reduction Plan (Piano di Rientro) procedure also for hospital bodies as an additional tool to restore budget balance positions and improve an efficient use of public resources.

Since 2015, a few interventions have been adopted in order to set and revise the level of resources for the financing of the public health care system:

- Law 208/2015 (art. 1, paragraph 508) has redefined the level of the financing resources in 111.002 euro for 2016 and set it to 113.063 euro for 2017, 114.998 for 2018 and 117.988 euro for 2019;
- Law 232/2016 (art. 1, paragraph 392) has downsized the level of the financing resources to 113.000 euro for 2017, 114.000 euro for 2018 and 115.000 euro for 2019;
- Decree foreseen by Law 232/2016, art. 1, paragraph 394 has further reduced the level of the financing resources to 112.577 euro for 2017, 113.396 euro for 2018 and 114.396 euro for 2019.

More recently, in January 2017, a decree was adopted that updated the basic health care levels (LEA), to be guaranteed to all citizens.

In the same year, a legislative intervention laid down the obligation for children younger than sixteen to undergo ten vaccines, charging the cost on the NHS.

#### **Challenges**

The analysis above shows that a range of reforms have been implemented in recent years, for example, to strengthen primary care provision and its use, to improve efficiency, to improve data collection, information and monitoring systems and the use of ICT solutions, to control overall expenditure and pharmaceutical expenditure while delivering quality healthcare. They were to a very large extent successful and, therefore, Italy should continue to pursue them. The main challenges for the Italian health care system are as follows:

- To continue increasing the efficiency of health care spending, promoting quality and integrated care as well as a focusing on costs, to tackle the impact on spending due to population ageing and non-demographic factors.
- To extend the possibilities of hospitals to provide ambulatory and day care as well as to transfer more health care services into the ambulatory sector in order to reduce the number of inpatient care treatments, as well as to strategically direct more resources towards providers of lower levels of care, to increase efficiency.
- To tackle unwarranted regional variation in waiting times and resource distribution. In particular, monitor and correct potential uneven distribution of hospital beds (follow-up and long-term care), to free-up capacity in acute settings as a driver of lower waiting times. To the same end, further develop ICT solutions to increase service efficiency of operations.
- To re-think the current mix between doctors and nurses, to favour solutions that relying less heavily on doctors, in the cases where nurses can represent a substitute, consistently with a more primary-care oriented system.
- To further the efforts in the field of pharmaceuticals by considering additional measures, both on the side of patients and of health care professionals, to improve the rational prescribing and usage of medicines. The policies could help reducing the high level of out-of-pocket payments and improving access to cost-effective new medicines by generating savings to the public payer.
- To ensure a greater and nationally coordinated use of health technology assessment to determine new high-cost equipment capacity, the benefit basket and the cost-sharing design across medical interventions.
- To implement the National Health Information System across all regions and sub-regional levels which has a strong potential to monitor and relate expenditure with activity and with outcomes and in identifying good practices and areas for improvement. To encourage debate, information exchange, and peer reviews between regions once the system is fully implemented. In this context, the patient e-card (*Tessera Sanitaria*) should be fully exploited.
- To continue to monitor regional expenditure policies making regions showing deficit in the health sector budget restore the balance and ensure efficiency and appropriateness in the provision of LEAs. To continue to improve accountability and governance of the system and identify possible cost-savings in the health sector administration, as it currently involves national and regional institutions.
- To further the efforts to support public health priorities and enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening.

Table 2.15.1: Statistical Annex – Italy

| General context  |       |       |       |       |       |       |       |       |       |       |       | EU- latest national data |        |        |        |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------------------------|--------|--------|--------|
| GDP  | 2005  | 2006  | 2007  | 2008  | 2009  | 2010  | 2011  | 2012  | 2013  | 2014  | 2015  | 2009                     | 2011   | 2013   | 2015   |
| GDP, in billion Euro, current prices   | 1,490 | 1,548 | 1,610 | 1,632 | 1,573 | 1,605 | 1,637 | 1,613 | 1,605 | 1,622 | 1,652 | 12,451                   | 13,213 | 13,559 | 14,447 |
| GDP per capita PPS (thousands)   | 27.8  | 28.6  | 29.2  | 28.4  | 26.1  | 26.5  | 26.7  | 26.3  | 25.3  | 25.3  | 26.1  | 26.8                     | 28.1   | 28.0   | 29.6   |
| Real GDP growth (% year-on-year) per capita  | 0.3   | 1.6   | 0.9   | -1.8  | -6.0  | 1.3   | 0.2   | -3.3  | -2.2  | -0.1  | 1.0   | -4.7                     | 1.5    | 0.1    | 2.0    |
| Real total health expenditure growth (% year-on-year) per capita                   | :     | 2.9   | -2.6  | 2.6   | -0.5  | 1.4   | -1.4  | -3.2  | -2.4  | 0.3   | 0.8   | 3.7                      | 0.2    | 0.2    | 4.1    |
| Expenditure on health*   | 2005  | 2006  | 2007  | 2008  | 2009  | 2010  | 2011  | 2012  | 2013  | 2014  | 2015  | 2009                     | 2011   | 2013   | 2015   |
| Total as % of GDP  | 8.7   | 8.8   | 8.5   | 8.9   | 9.4   | 9.4   | 9.3   | 9.3   | 9.3   | 9.3   | 9.3   | 10.2                     | 10.1   | 10.1   | 10.2   |
| Total current as % of GDP  | 7.9   | 7.9   | 8.2   | 8.4   | 8.5   | 8.2   | 8.6   | 9.0   | 9.0   | 9.0   | 9.0   | 9.3                      | 9.4    | 9.9    | 9.9    |
| Total capital investment as % of GDP   | 0.8   | 1.0   | 0.3   | 0.5   | 0.9   | 1.3   | 0.7   | 0.3   | 0.3   | 0.3   | 0.3   | 0.9                      | 0.6    | 0.2    | 0.3    |
| Total per capita PPS   | 2,219 | 2,328 | 2,329 | 2,448 | 2,483 | 2,527 | 2,531 | 2,495 | 2,463 | 2,455 | 2,495 | 2,745                    | 2,895  | 2,975  | 3,305  |
| Public total as % of GDP   | 6.8   | 6.9   | 6.6   | 7.0   | 7.4   | 7.4   | 7.1   | 7.1   | 7.1   | 7.1   | 7.0   | 8.0                      | 7.8    | 7.8    | 8.0    |
| Public current as % of GDP   | 6.5   | 6.6   | 6.3   | 6.7   | 7.0   | 7.0   | 6.8   | 6.8   | 6.8   | 6.8   | 6.7   | 7.7                      | 7.6    | 7.6    | 7.8    |
| Public total per capita PPS  | 1,732 | 1,817 | 1,819 | 1,925 | 1,960 | 1,981 | 1,935 | 1,916 | 1,894 | 1,877 | 1,887 | 2,153                    | 2,263  | 2,324  | 2,609  |
| Public capital investment as % of GDP  | 0.32  | 0.31  | 0.32  | 0.34  | 0.40  | 0.36  | 0.28  | 0.31  | 0.31  | 0.29  | 0.28  | 0.2                      | 0.2    | 0.2    | 0.2    |
| Public as % total expenditure on health  | 78.1  | 78.1  | 78.1  | 78.6  | 79.0  | 78.4  | 76.5  | 76.8  | 76.9  | 76.4  | 75.6  | 78.1                     | 77.5   | 79.4   | 78.4   |
| Public expenditure on health in % of total government expenditure                  | 15.1  | 14.5  | 15.1  | 14.9  | 14.6  | 14.5  | 14.2  | 13.9  | 14.1  | 13.9  | 13.9  | 14.8                     | 14.8   | 15.2   | 15.0   |
| Proportion of the population covered by public or primary private health insurance | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 99.6                     | 99.1   | 98.9   | 98.0   |
| Out-of-pocket expenditure on health as % of total current expenditure on health    | 20.7  | 20.4  | 20.7  | 20.6  | 19.7  | 19.5  | 21.0  | 21.7  | 21.8  | 22.1  | 22.8  | 14.6                     | 14.9   | 15.9   | 15.9   |

Note: \*Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

| Population and health status                      | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2009  | 2011  | 2013  | 2015  |
|---|------|------|------|------|------|------|------|------|------|------|------|-------|-------|-------|-------|
| Population, current (millions)                    | 57.9 | 58.1 | 58.2 | 58.7 | 59.0 | 59.2 | 59.4 | 59.4 | 59.7 | 60.8 | 60.8 | 502.1 | 503.0 | 505.2 | 508.5 |
| Life expectancy at birth for females              | 83.6 | 84.1 | 84.2 | 84.2 | 84.3 | 84.7 | 84.8 | 84.8 | 85.2 | 85.6 | 84.9 | 82.6  | 83.1  | 83.3  | 83.3  |
| Life expectancy at birth for males                | 78.1 | 78.6 | 78.8 | 78.9 | 79.1 | 79.5 | 79.7 | 79.8 | 80.3 | 80.7 | 80.3 | 76.6  | 77.3  | 77.7  | 77.9  |
| Healthy life years at birth females               | 67.8 | 64.7 | 62.6 | 61.8 | 62.6 | :    | 62.7 | 61.5 | 60.9 | 62.3 | 62.7 | 62.0  | 62.1  | 61.5  | 63.3  |
| Healthy life years at birth males                 | 66.6 | 65.2 | 63.4 | 62.9 | 63.4 | :    | 63.5 | 62.1 | 61.8 | 62.5 | 62.6 | 61.3  | 61.7  | 61.4  | 62.6  |
| Amenable mortality rates per 100 000 inhabitants* | :    | 62   | 61   | 61   | 59   | 55   | 100  | 99   | 94   | 90   | 93   | 64    | 138   | 131   | 127   |
| Infant mortality rate per 1 000 live births       | 3.3  | 3.2  | 3.1  | 3.1  | 3.2  | 3.0  | 2.9  | 2.9  | 2.9  | 2.8  | 2.9  | 4.2   | 3.9   | 3.7   | 3.6   |

Notes: Amenable mortality rates break in series in 2011.

| System characteristics                                |      |      |      |      |      |      |      |      |      |      |      | EU- latest national data |      |      |      |
|---|------|------|------|------|------|------|------|------|------|------|------|--------------------------|------|------|------|
| Composition of total current expenditure as % of GDP  | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2009                     | 2011 | 2013 | 2015 |
| Inpatient curative and rehabilitative care            | :    | :    | :    | :    | :    | :    | :    | 2.7  | 2.6  | 2.6  | 2.5  | 2.7                      | 2.6  | 2.7  | 2.7  |
| Day cases curative and rehabilitative care            | :    | :    | :    | :    | :    | :    | :    | 0.4  | 0.4  | 0.4  | 0.4  | 0.2                      | 0.2  | 0.3  | 0.3  |
| Out-patient curative and rehabilitative care          | 3.0  | 3.0  | 2.9  | 3.1  | 3.3  | 3.3  | 3.3  | 1.9  | 1.9  | 2.0  | 2.0  | 2.5                      | 2.5  | 2.4  | 2.4  |
| Pharmaceuticals and other medical non-durables        | 1.7  | 1.7  | 1.6  | 1.6  | 1.7  | 1.7  | 1.6  | 1.5  | 1.5  | 1.5  | 1.6  | 1.2                      | 1.2  | 1.5  | 1.4  |
| Therapeutic appliances and other medical durables     | :    | :    | :    | :    | :    | :    | :    | 0.3  | 0.3  | 0.3  | 0.3  | 0.3                      | 0.3  | 0.4  | 0.4  |
| Prevention and public health services                 | 0.2  | 0.2  | 0.2  | 0.2  | 0.3  | 0.3  | 0.2  | 0.4  | 0.4  | 0.4  | 0.4  | 0.3                      | 0.2  | 0.3  | 0.3  |
| Health administration and health insurance            | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.2  | 0.2  | 0.2  | 0.2  | 0.4                      | 0.4  | 0.4  | 0.4  |
| Composition of public current expenditure as % of GDP | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2009                     | 2011 | 2013 | 2015 |
| Inpatient curative and rehabilitative care            | :    | :    | :    | :    | :    | :    | :    | 2.6  | 2.5  | 2.5  | 2.4  | 2.6                      | 2.5  | 2.5  | 2.5  |
| Day cases curative and rehabilitative care            | :    | :    | :    | :    | :    | :    | :    | 0.4  | 0.4  | 0.4  | 0.4  | 0.1                      | 0.2  | 0.3  | 0.3  |
| Out-patient curative and rehabilitative care          | 2.0  | 2.1  | 2.2  | 2.1  | 2.2  | 2.4  | 2.5  | 1.2  | 1.2  | 1.2  | 1.2  | 1.8                      | 1.8  | 1.7  | 1.8  |
| Pharmaceuticals and other medical non-durables        | 0.9  | 0.9  | 0.9  | 0.9  | 0.9  | 0.9  | 0.8  | 0.9  | 0.9  | 0.9  | 1.0  | 0.9                      | 0.9  | 1.0  | 1.0  |
| Therapeutic appliances and other medical durables     | :    | :    | :    | :    | :    | :    | :    | 0.1  | 0.1  | 0.1  | 0.1  | 0.1                      | 0.1  | 0.2  | 0.2  |
| Prevention and public health services                 | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.0  | 0.3  | 0.3  | 0.3  | 0.3  | 0.2                      | 0.2  | 0.2  | 0.3  |
| Health administration and health insurance            | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.1  | 0.3                      | 0.3  | 0.3  | 0.3  |

Source: EUROSTAT, OECD and WHO.

Table 2.15.2: Statistical Annex - continued - Italy

| Composition of total as % of total current health expenditure          | 2005        | 2006        | 2007        | 2008        | 2009        | 2010        | 2011        | 2012        | 2013        | 2014        | 2015        | EU - latest national data |                                  |       |       |  |
|--|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|---------------------------|----------------------------------|-------|-------|--|
|  | 2009        | 2011        | 2013        | 2015        |             |             |             |             |             |             |             |                           |                                  |       |       |  |
| Inpatient curative and rehabilitative care                             | :           | :           | :           | :           | :           | :           | :           | 30.0%       | 29.4%       | 28.6%       | 27.9%       | 29.1%                     | 27.9%                            | 27.1% | 27.0% |  |
| Day cases curative and rehabilitative care                             | :           | :           | :           | :           | :           | :           | :           | 4.6%        | 4.2%        | 4.3%        | 4.2%        | 1.7%                      | 1.7%                             | 3.0%  | 3.1%  |  |
| Out-patient curative and rehabilitative care                           | 37.9%       | 38.3%       | 35.8%       | 37.0%       | 39.1%       | 40.9%       | 38.9%       | 21.1%       | 21.5%       | 22.2%       | 22.7%       | 26.8%                     | 26.3%                            | 23.7% | 24.0% |  |
| Pharmaceuticals and other medical non-durables                         | 21.6%       | 21.7%       | 19.9%       | 19.7%       | 20.1%       | 20.6%       | 19.1%       | 16.5%       | 17.0%       | 17.0%       | 17.9%       | 13.1%                     | 12.8%                            | 14.7% | 14.6% |  |
| Therapeutic appliances and other medical durables                      | :           | :           | :           | :           | :           | :           | :           | 2.8%        | 2.8%        | 2.9%        | 2.8%        | 3.6%                      | 3.6%                             | 4.1%  | 4.1%  |  |
| Prevention and public health services                                  | 2.8%        | 2.9%        | 2.8%        | 2.9%        | 3.0%        | 3.1%        | 2.8%        | 4.0%        | 4.0%        | 4.1%        | 4.0%        | 2.8%                      | 2.5%                             | 3.0%  | 3.1%  |  |
| Health administration and health insurance                             | 0.9%        | 1.0%        | 0.9%        | 1.0%        | 1.0%        | 1.2%        | 1.1%        | 1.9%        | 1.9%        | 1.8%        | 1.9%        | 4.5%                      | 4.3%                             | 3.9%  | 3.8%  |  |
| <b>Composition of public as % of public current health expenditure</b> |             |             |             |             |             |             |             |             |             |             |             |                           |                                  |       |       |  |
| Inpatient curative and rehabilitative care                             | :           | :           | :           | :           | :           | :           | :           | 38.1%       | 37.2%       | 36.4%       | 35.9%       | 33.9%                     | 33.6%                            | 32.1% | 31.9% |  |
| Day cases curative and rehabilitative care                             | :           | :           | :           | :           | :           | :           | :           | 5.6%        | 5.1%        | 5.3%        | 5.2%        | 1.9%                      | 2.0%                             | 3.4%  | 3.5%  |  |
| Out-patient curative and rehabilitative care                           | 30.6%       | 32.6%       | 34.1%       | 31.5%       | 31.5%       | 34.4%       | 36.2%       | 17.4%       | 17.9%       | 18.2%       | 18.1%       | 22.9%                     | 23.5%                            | 22.2% | 22.5% |  |
| Pharmaceuticals and other medical non-durables                         | 14.0%       | 13.9%       | 13.6%       | 12.8%       | 12.9%       | 12.8%       | 12.3%       | 13.0%       | 13.5%       | 13.8%       | 15.0%       | 11.8%                     | 11.9%                            | 12.6% | 12.7% |  |
| Therapeutic appliances and other medical durables                      | :           | :           | :           | :           | :           | :           | :           | 0.7%        | 0.7%        | 0.7%        | 0.7%        | 1.8%                      | 1.9%                             | 2.0%  | 2.1%  |  |
| Prevention and public health services                                  | 0.5%        | 0.5%        | 0.6%        | 0.6%        | 0.6%        | 0.6%        | 0.6%        | 4.7%        | 4.8%        | 4.8%        | 4.7%        | 2.9%                      | 2.5%                             | 3.2%  | 3.2%  |  |
| Health administration and health insurance                             | 1.1%        | 1.2%        | 1.2%        | 1.2%        | 1.2%        | 1.4%        | 1.4%        | 1.8%        | 1.6%        | 1.6%        | 1.6%        | 4.1%                      | 4.0%                             | 3.6%  | 3.4%  |  |
| <b>Expenditure drivers (technology, life style)</b>                    |             |             |             |             |             |             |             |             |             |             |             |                           |                                  |       |       |  |
| MRI units per 100 000 inhabitants                                      | 1.48        | 1.67        | 1.85        | 1.97        | 2.12        | 2.20        | 2.36        | 2.46        | 2.52        | 2.62        | 2.82        | 1.0                       | 1.4                              | 1.5   | 1.9   |  |
| Angiography units per 100 000 inhabitants                              | :           | :           | 1.0         | 1.1         | 1.2         | 1.2         | 1.3         | 1.3         | 1.3         | 1.4         | 1.4         | 0.9                       | 0.9                              | 0.9   | 1.0   |  |
| CTS per 100 000 inhabitants  | 2.8         | 2.9         | 3.0         | 3.0         | 3.1         | 3.2         | 3.2         | 3.3         | 3.3         | 3.3         | 3.3         | 2.1                       | 1.9                              | 2.1   | 2.3   |  |
| PET scanners per 100 000 inhabitants                                   | :           | :           | 0.2         | 0.2         | 0.2         | 0.2         | 0.2         | 0.3         | 0.3         | 0.3         | 0.3         | 0.1                       | 0.1                              | 0.2   | 0.2   |  |
| Proportion of the population that is obese                             | 9.9         | 10.2        | 9.9         | 9.9         | 10.3        | 10.3        | 10.0        | 10.4        | 10.3        | 10.5        | 9.8         | 15.0                      | 15.1                             | 15.5  | 15.4  |  |
| Proportion of the population that is a regular smoker                  | 22.3        | 23.0        | 22.4        | 22.4        | 23.3        | 23.1        | 22.5        | 22.1        | 21.1        | 19.7        | 19.8        | 23.2                      | 22.3                             | 21.8  | 20.9  |  |
| Alcohol consumption litres per capita                                  | 8.7         | 8.4         | 8.4         | 8.0         | 7.3         | 7.0         | 7.0         | 7.5         | 7.3         | 7.6         | :           | 10.4                      | 10.3                             | 10.1  | 10.2  |  |
| <b>Providers</b>   |             |             |             |             |             |             |             |             |             |             |             |                           |                                  |       |       |  |
| Practising physicians per 100 000 inhabitants                          | :           | :           | :           | :           | 368         | :           | :           | 387         | 390         | 388         | 384         | 324                       | 330                              | 338   | 344   |  |
| Practising nurses per 100 000 inhabitants                              | :           | :           | :           | :           | :           | :           | :           | :           | 508         | 528         | 544         | 837                       | 835                              | 825   | 833   |  |
| General practitioners per 100 000 inhabitants                          | 80          | 79          | 79          | 78          | 77          | 76          | 76          | 76          | 75          | 74          | 74          | 77                        | 78                               | 78    | 78    |  |
| Acute hospital beds per 100 000 inhabitants                            | 690         | 617         | 608         | 559         | 553         | 546         | 535         | 528         | 523         | 524         | 518         | 416                       | 408                              | 407   | 402   |  |
| <b>Outputs</b>   |             |             |             |             |             |             |             |             |             |             |             |                           |                                  |       |       |  |
| Doctors consultations per capita                                       | 6.1         | :           | :           | :           | :           | :           | :           | :           | 6.8         | :           | :           | 6.2                       | 6.2                              | 6.2   | 6.3   |  |
| Hospital inpatient discharges per 100 inhabitants                      | 15          | 14          | 14          | 14          | 13          | 13          | 12          | 12          | 11          | 11          | 11          | 17                        | 16                               | 16    | 16    |  |
| Day cases discharges per 100 000 inhabitants                           | 6,803       | 6,649       | 6,156       | 5,958       | 5,414       | 5,097       | 4,757       | 4,350       | 4,070       | 3,771       | 3,467       | 6,362                     | 6,584                            | 7,143 | 7,635 |  |
| Acute care bed occupancy rates   | 77.0        | 78.0        | 78.3        | 78.8        | 79.4        | 78.7        | 78.5        | 77.5        | 77.3        | 77.6        | 78.9        | 77.1                      | 76.4                             | 76.5  | 76.8  |  |
| Hospital average length of stay  | 6.7         | 6.7         | 7.5         | 7.6         | 7.6         | 7.6         | 7.7         | 7.7         | 7.7         | 7.8         | 7.8         | 8.0                       | 7.8                              | 7.7   | 7.6   |  |
| Day cases as % of all hospital discharges                              | 31.8        | 31.5        | 30.7        | :           | 29.0        | 28.5        | 28.0        | 26.4        | 25.6        | 24.8        | 23.2        | 28.0                      | 29.1                             | 30.9  | 32.3  |  |
| <b>Population and Expenditure projections</b>                          |             |             |             |             |             |             |             |             |             |             |             |                           |                                  |       |       |  |
| <b>Projected public expenditure on healthcare as % of GDP*</b>         | <b>2016</b> | <b>2020</b> | <b>2025</b> | <b>2030</b> | <b>2035</b> | <b>2040</b> | <b>2045</b> | <b>2050</b> | <b>2055</b> | <b>2060</b> | <b>2065</b> | <b>2070</b>               | <b>Change 2016-2070, in pps.</b> |       |       |  |
| AWG reference scenario   | 6.3         | 6.2         | 6.3         | 6.5         | 6.7         | 6.9         | 7.1         | 7.2         | 7.2         | 7.1         | 7.0         | 7.0                       | Italy                            | EU    |       |  |
| AWG risk scenario  | 6.3         | 6.2         | 6.5         | 6.7         | 6.9         | 7.1         | 7.3         | 7.5         | 7.6         | 7.5         | 7.5         | 7.5                       | 0.7                              | 0.9   |       |  |
| Note: *Excluding expenditure on medical long-term care component.      |             |             |             |             |             |             |             |             |             |             |             |                           | 1.1                              | 1.6   |       |  |
| <b>Population projections</b>  |             |             |             |             |             |             |             |             |             |             |             |                           | <b>Change 2016-2070, in %</b>    |       |       |  |
| Population projections until 2070 (millions)                           | 2016        | 2020        | 2025        | 2030        | 2035        | 2040        | 2045        | 2050        | 2055        | 2060        | 2065        | 2070                      | Italy                            | EU    |       |  |
|  | 60.8        | 60.7        | 60.5        | 60.4        | 60.2        | 60.0        | 59.6        | 59.0        | 58.0        | 56.9        | 55.8        | 54.9                      | -9.6                             | 2.0   |       |  |

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

## Italy

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Long-term care systems

## 3.15. ITALY

### General context: Expenditure, fiscal sustainability and demographic trends

With almost 61 million inhabitants, Italy has more than 12% of the total EU population in 2016 <sup>(517)</sup>. This makes it the fourth largest country in terms of population, after Germany, France and the United Kingdom. During the coming decennia the population of Italy will steadily decrease, from 60.8 million inhabitants in 2016 to 54.9 million inhabitants in 2070. This 9.6% decrease represents a gap of about 11 pps from the EU average population, which is overall projected to increase by 2%.

With a GDP of some €1,650 bn (11% of the EU's total GDP), or 26,100 PPS per capita, the value for 2015 is lower than the EU average of 29,610. Based on the Ageing Report 2018 <sup>(518)</sup>, total public expenditure on long-term care (health and social part) <sup>(519)</sup> is, with 1.7% of GDP in 2015, slightly above the EU average in the same year (1.6%). However, the health component, with 0.7% in 2015, is lower than the EU average of 1.2% in the same year.

### Health status

Life expectancy at birth for both women and men is in 2015 respectively 84.9 years and 80.3 years and is above the EU average (83.3 and 77.9 years respectively). The healthy life years at birth for both sexes are with 62.7 years (women) and 62.6 years (men) similar to the EU-average (63.3 and 62.6 respectively). The percentage of the population having a long-standing illness has, though with fluctuations, increased through the decade going from 21.6% (2006) to 24.8%, in 2015, but it is well below the EU-average (34.2% in 2015). On the other hand, the percentage of the population indicating a self-perceived severe limitation in its daily activities, which has also been increasing from 7.1% (2006) to 9.4% (2015), is above the EU-average (8.1% in 2015).

<sup>(517)</sup> Based on Eurostat projections.

<sup>(518)</sup> The 2018 Ageing Report: [https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070\\_en](https://ec.europa.eu/info/publications/economy-finance/2018-ageing-report-economic-and-budgetary-projections-eu-member-states-2016-2070_en).

<sup>(519)</sup> Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with tasks linked with Activities with Daily Living).

### Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase significantly over the coming 50 years. From 5.48 million residents living with strong limitations due to health problems in 2016, an increase of 19% is envisaged until 2070 to around 6.53 million. That is less steep an increase than for the EU as a whole (25%). Also as a share of the population the dependents are becoming a bigger group, going from 9.0% in 2016 to 11.9% in 2070, an increase of 32%, above the EU average of 21% over the same period <sup>(520)</sup>.

### Expenditure projections and fiscal sustainability

With the demographic changes, the public expenditure on long-term care as a percentage of GDP is projected to steadily increase. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 1.3 pps of GDP, from 1.7% in 2016 to 3.0% by 2070 <sup>(521)</sup>. The "AWG risk scenario", which also captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.2 pps of GDP by 2070, bringing long-term care spending in Italy from 1.7% to 3.9% over the same period. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. Medium and long-term sustainability risks, which are classified as high for Italy, mainly derive from the high debt-to-GDP ratio and do not stem from long-term care expenditure and the projected cost of ageing <sup>(522)</sup>.

### System Characteristics

Public expenditure on long-term care (LTC) includes three components: i) long-term care services to dependent people provided by the public health care system, ii) the social component

<sup>(520)</sup> The 2018 Ageing Report.

<sup>(521)</sup> The 2018 Ageing Report.

<sup>(522)</sup> European Commission, Fiscal Sustainability Report (2018) [https://ec.europa.eu/info/sites/info/files/economy-finance/ip094\\_en\\_vol\\_2.pdf](https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf).

of long-term care provisions provided by municipalities and iii) attendance allowances (*indennità di accompagnamento*)<sup>(523)</sup>.

The overall expenditure accounts for 1.7 percentage points of GDP in 2016 and refers to all long-term care provisions financed by public resources, regardless of the age of recipients. Since the incidence of dependency is strongly linked to age, about three quarter of the expenditure is directed at the elderly over 65.

The health component of long-term care is provided by Regions through the local health authorities (*Aziende Sanitarie Locali*, ASLs) and accounts for about 40% of the total public expenditure on long-term care.

The social component of long-term care services includes a heterogeneous group of benefits, largely in kind, mainly provided at a local level by municipalities, directly or in association. These provisions are generally means-tested.

Both health and social long-term care provisions include home and residential care services. The admission to long-term care services is based on needs but also on income levels: co-payments may play a relevant role and together with the waiting lists tend to shape the users' profile.

Investment in home care is average compared to other countries, although this type of service is fundamentally and informally supported by migrant care workers that are paid directly by families, also through the use of the attendance allowance. This partly explains the fact that investment in residential care is, on the contrary, relatively weak. Nevertheless, the relatively low coverage of residential care may create tensions on public home care provision insofar as severe cases, that could be treated through different forms of residential care (last stages of Alzheimer or other forms of dementia, etc.), might be left at home.

Attendance allowances are based on a cash allowance programme for individuals with very severe disability. They are not means-tested and

they are run by the *National Institute of Social Security – INPS* and financed through general taxation. The attendance allowance accounts for about 500 euros<sup>(524)</sup> per month (for 12 months) and it is provided directly to the dependent person. Different amounts are foreseen for particular categories of disability such as the blind or the deaf-mute. Italy spent in 2017 the equivalent of 0.89% of its GDP in long-term care cash benefits, of which 0.79% of GDP for attendance allowances alone. The share of this type of care was in 2017 about 52% of total long-term care expenditure (46% for attendance allowances alone), nearly four fifty of which covers the frail elderly over 65<sup>(525)</sup>.

#### *Administrative organisation*

The actors directly involved in the organisation of long-term care services are municipalities, local health authorities - ASLs), nursing homes (*residenze sanitarie assistenziali*- RSAs) and the National Institute of Social Security (*INPS*), but other players are involved in planning and funding these services – i.e. the central state, regions and provinces. Additionally, in Italy individual households play an important role in the organisation and provision of long-term care.

#### *Types of care*

In Italy, public long-term care for older persons includes three main kinds of formal assistance: community care, residential care and cash benefits. The Italian National Health Service (*Servizio Sanitario Nazionale*, SSN) plans and manages, through local health units (*aziende Sanitarie locali*), home health-care services – the so-called 'integrated domiciliary care' provided by the *Assistenza Domiciliare Integrata (ADI)* – and other health services provided in residential settings. Personal social services, both domestic and personal care tasks, provided at home by the *Servizi di Assistenza Domiciliare (SAD)*, and institutional social care are managed at a local level by municipalities, although this should be planned in coordination with the ADI. In practice, there may be significant differences between different municipalities in terms of spending on

<sup>(523)</sup> Ministero dell'economia e delle finanze - RGS (2018), Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario, Report no. 19.

[http://www.rgs.mef.gov.it/VERSIONE-I/attivita\\_istituzionali/monitoraggio/spesa\\_pensionistica/](http://www.rgs.mef.gov.it/VERSIONE-I/attivita_istituzionali/monitoraggio/spesa_pensionistica/).

<sup>(524)</sup> Specifically, 516.35 euros in 2018.

<sup>(525)</sup> Ministero dell'economia e delle finanze - RGS (2018), Le tendenze di medio-lungo periodo del sistema pensionistico e socio-sanitario, Report no. 19.



care provided. Levels of institutionalisation of patients differs also between regions. Long-term care is delivered by both public and accredited private providers of health and personal social care. In terms of shares of long-term care spending, Italy stands well above average (52.2% vs. 15.6% for the EU in 2016) as for the share to fund cash benefits. This is paired with comparatively generous allowances with respect to the EU average, with unit costs of cash benefits per recipients as a share of GDP per capita standing at 28.9 vs. 11.8 in 2016. This measure gives an indication of the proportion between the spending on cash allowances and the available resources.

#### *Eligibility criteria*

In Italy there is not one single, national legal definition of persons in need of care to which one can refer.

To obtain services in-kind for long-term care, there is not the same unique system. Indeed, ASLs of the Italian National Health Service are responsible for assessing the degree of disability of citizens living in their catchment area, but their criteria are not homogeneous. For most health and social services, the needs assessments are carried out by a multidisciplinary team of the ASL – in most of them by the geriatric evaluation units (*Unità di Valutazione Geriatrica*), which include doctors, nurses, social workers and sometimes administrative employees. This team in some cases classifies the claimants into categories of need, sets out the care plan and chooses the type of provider.

However, to obtain the cash benefits provided by the *INPS*, each region refers to the same classification system: a claimant must apply to the Local Health Authority Service (ASL) in charge of deciding whether the health requirements (in terms of disability and dependence) are present, through its medical commission. If this is the case, the claimant is referred to an *INPS* commission, which makes the final decision.

#### *Co-payments, out of the pocket expenses and private insurance*

Neither the access nor the amount of social transfers related to the cash benefits programme (the “Attendance Allowances”) are means-tested. This points to scope to increase efficiency,

especially considering the current structure of long-term care provision with generous cash benefits. The Attendance Allowance is provided only on the base of needs. The criteria of access to residential and home care are somewhat differentiated in the country as well as the criteria of co-payment. Practically in the whole country means-testing is applied to define the amount of economic resources households have to provide in order to receive the service.

#### *Role of the private sector*

Private providers of long-term care (both for-profit and not-for-profit) have a share of 65% of all institutional long-term care beds.

Private home care is increasingly important in the Italian long-term care system, although there are no official data on this aspect. According to the little data available, 6.6% of those aged over 65 (NNA, 2009) received home care privately. Private home care is provided mainly by migrant workers on individual basis: in 2008 it was estimated that around 700,000 migrant workers were employed to provide home care to elderly persons (NNA, 2009).

#### *Formal/informal caregiving*

Informal care is extremely important in the Italian social protection system, but the data available are limited.

Generally speaking, in northern Italy the culture of public (formal) service in long-term care is rather widespread, partly owing to the high level of participation by women in the labour market. These regions – and municipalities – have been making an effort to improve their long-term care system, thanks also to their more developed management capabilities and their larger economic resources. In the south, by contrast, the care burden rests mostly on families (informal caregiving), with poor public (formal) support.

#### *Prevention and rehabilitation policies/measures*

Rehabilitative health care services, included in the long-term care definition, are provided to disabled people at home or in residences, generally as a part

of more general assistance programmes related to dependency.

### Recently legislated and/or planned policy reforms

The health component for long-term care provisions depends, amongst the others, on the level of resources for the financing of the public health care system. In this regard, the following interventions should be mentioned:

- Law 208/2015 (art. 1, paragraph 508) has redefined the level of the financing resources in 111.002 million euro for 2016 and set it to 113.063 million euro for 2017, 114.998 million for 2018 and 117.988 euro million for 2019;
- The Stability law for 2017, Law 232/2016 (art. 1, paragraph 392) has downsized the level of the financing resources to 113.000 million euro for 2017, 114.000 million euro for 2018 and 115.000 million euro for 2019;
- Decree foreseen by Law 232/2016, art. 1, paragraph 394 has further reduced the level of the financing resources to 112.577 million euro for 2017, 113.396 million euro for 2018 and 114.396 million euro for 2019.

Furthermore, the budget law for 2017 has increased the Fund for dependents in the State budget (*Fondo per la non autosufficienza*) up to 450 million euro per year and made it permanent as of 2017. Resources in the Fund are transferred to Regions to finance services and benefits, generally in kind, for people with severe disabilities.

Lastly, the Law 112/2016 allocated financial resources of above 50 million euro per year to a new Fund targeted to support severely disabled people surviving their parents.

### Challenges

Italy has a system of long-term care that focuses on cash benefits as much as on residential and home care. Based on the current features, the main challenges of the system appear to be:

- **Improving the governance framework:** to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to deal with cost-shifting incentives across health and care.
- **Improving financing arrangements:** to determine the extent of user cost-sharing on long term care benefits; to extend means-testing to cash benefit provisions, to include assets in the means-test used to determine individual cost-sharing (or entitlement to public support) for B&L costs better reflects the distribution of economic welfare among individuals.
- **Providing adequate levels of care to those in need of care:** to adapt and improve long term care coverage schemes, setting a homogenous need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on long term care benefits; to provide targeted benefits to those with highest LTC needs.
- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.
- **Ensuring coordination and continuity of care:** to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance

structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for long term care; to create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; to steer long term care users towards appropriate settings.
- **Improving value for money:** to invest in ICT as an important source of information, care management and coordination; to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services.
- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.
- **Improving administrative efficiency.**

Table 3.15.1: Statistical Annex – Italy

| GENERAL CONTEXT  |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|---------|---------|---------|---------|
|  | 2005  | 2006  | 2007  | 2008  | 2009  | 2010  | 2011  | 2012  | 2013  | 2014  | 2015  | EU 2009 | EU 2011 | EU 2013 | EU 2015 |
| <b>GDP and Population</b>  |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
| GDP, in billion euro, current prices   | 1,490 | 1,548 | 1,610 | 1,632 | 1,573 | 1,605 | 1,637 | 1,613 | 1,605 | 1,622 | 1,652 | 12,451  | 13,213  | 13,559  | 14,447  |
| GDP per capita, PPS  | 27.8  | 28.6  | 29.2  | 28.4  | 26.1  | 26.5  | 26.7  | 26.3  | 25.3  | 25.3  | 26.1  | 26.8    | 28.1    | 28.0    | 29.6    |
| Population, in millions  | 57.9  | 58.1  | 58.2  | 58.7  | 59.0  | 59.2  | 59.4  | 59.4  | 59.7  | 60.8  | 60.8  | 502     | 503     | 505     | 509     |
| <b>Public expenditure on long-term care (health)</b>   |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
| As % of GDP  | :     | :     | :     | :     | :     | :     | :     | 0.7   | 0.7   | 0.7   | 0.7   | 1.1     | 1.2     | 1.2     | 1.2     |
| Per capita PPS   | :     | :     | :     | :     | :     | :     | :     | 186.9 | 184.8 | 185.8 | 188.6 | 264.1   | 283.2   | 352.1   | 373.6   |
| As % of total government expenditure   | :     | :     | :     | :     | :     | :     | :     | 1.4   | 1.4   | 1.4   | 1.4   | 1.6     | 1.8     | 2.5     | 2.5     |
| Note: Based on OECD, Eurostat - System of Health Accounts  |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
| <b>Health status</b>   |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
| Life expectancy at birth for females   | 83.6  | 84.1  | 84.2  | 84.2  | 84.3  | 84.7  | 84.8  | 84.8  | 85.2  | 85.6  | 84.9  | 82.6    | 83.1    | 83.3    | 83.3    |
| Life expectancy at birth for males   | 78.1  | 78.6  | 78.8  | 78.9  | 79.1  | 79.5  | 79.7  | 79.8  | 80.3  | 80.7  | 80.3  | 76.6    | 77.3    | 77.7    | 77.9    |
| Healthy life years at birth for females  | 67.8  | 64.7  | 62.6  | 61.8  | 62.6  | :     | 62.7  | 61.5  | 60.9  | 62.3  | 62.7  | 62.0    | 62.1    | 61.5    | 63.3    |
| Healthy life years at birth for males  | 66.6  | 65.2  | 63.4  | 62.9  | 63.4  | :     | 63.5  | 62.1  | 61.8  | 62.5  | 62.6  | 61.3    | 61.7    | 61.4    | 62.6    |
| People having a long-standing illness or health problem, in % of pop.  | :     | 21.6  | 21.2  | 22.6  | 22.1  | 22.6  | 26.7  | 24.9  | 25.3  | 24.8  | 24.8  | 31.3    | 31.7    | 32.5    | 34.2    |
| People having self-perceived severe limitations in daily activities (% of pop.)                              | :     | 7.1   | 7.6   | 8.2   | 8.0   | :     | 8.7   | 9.5   | 9.5   | 9.0   | 9.4   | 8.3     | 8.3     | 8.7     | 8.1     |
| <b>SYSTEM CHARACTERISTICS</b>  |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
|  | 2005  | 2006  | 2007  | 2008  | 2009  | 2010  | 2011  | 2012  | 2013  | 2014  | 2015  | EU 2009 | EU 2011 | EU 2013 | EU 2015 |
| <b>Coverage (Based on data from Ageing Reports)</b>  |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
| Number of people receiving care in an institution, in thousands  | :     | :     | 165   | 201   | 237   | 273   | 276   | 280   | 294   | 299   | 302   | 3,433   | 3,851   | 4,183   | 4,313   |
| Number of people receiving care at home, in thousands  | :     | :     | 359   | 498   | 637   | 775   | 782   | 791   | 754   | 767   | 777   | 6,442   | 7,444   | 6,700   | 6,905   |
| % of pop. receiving formal LTC in-kind   | :     | :     | 0.9   | 1.2   | 1.5   | 1.8   | 1.8   | 1.8   | 1.8   | 1.8   | 1.8   | 2.0     | 2.2     | 2.2     | 2.2     |
| Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
| <b>Providers</b>   |       |       |       |       |       |       |       |       |       |       |       |         |         |         |         |
| Number of informal carers, in thousands  | :     | :     | :     | :     | :     | :     | :     | :     | :     | :     | :     | :       | :       | :       | :       |
| Number of formal carers, in thousands  | :     | :     | :     | :     | :     | :     | :     | :     | :     | :     | :     | :       | :       | :       | :       |

Source: EUROSTAT, OECD and WHO.

Table 3.15.2: Statistical Annex - continued – Italy

| PROJECTIONS   |           |           |           |           |           |           |           |                     |                     |
|---|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---------------------|---------------------|
|   | 2016      | 2020      | 2030      | 2040      | 2050      | 2060      | 2070      | MS Change 2016-2070 | EU Change 2016-2070 |
| <b>Population</b>   |           |           |           |           |           |           |           |                     |                     |
| Population projection in millions   | 60.8      | 60.7      | 60.3      | 60.0      | 58.9      | 56.8      | 54.9      | -10%                | 2%                  |
| <b>Dependency</b>   |           |           |           |           |           |           |           |                     |                     |
| Number of dependents in millions  | 5.48      | 5.68      | 6.16      | 6.68      | 7.12      | 7.02      | 6.53      | 19%                 | 25%                 |
| Share of dependents, in %   | 9.0       | 9.4       | 10.2      | 11.1      | 12.1      | 12.4      | 11.9      | 32%                 | 21%                 |
| <b>Projected public expenditure on LTC as % of GDP</b>                        |           |           |           |           |           |           |           |                     |                     |
| AWG reference scenario  | 1.7       | 1.8       | 2.0       | 2.3       | 2.8       | 3.1       | 3.0       | 71%                 | 73%                 |
| AWG risk scenario   | 1.7       | 1.8       | 2.1       | 2.6       | 3.3       | 3.8       | 3.9       | 128%                | 170%                |
| <b>Coverage</b>   |           |           |           |           |           |           |           |                     |                     |
| Number of people receiving care in an institution                             | 684,968   | 709,591   | 762,424   | 841,051   | 947,077   | 983,824   | 910,855   | 33%                 | 72%                 |
| Number of people receiving care at home                                       | 673,543   | 721,887   | 829,866   | 968,574   | 1,144,280 | 1,208,538 | 1,113,783 | 65%                 | 86%                 |
| Number of people receiving cash benefits                                      | 1,886,527 | 1,990,604 | 2,212,474 | 2,509,581 | 2,889,635 | 3,014,888 | 2,781,765 | 47%                 | 52%                 |
| % of pop. receiving formal LTC in-kind and/or cash benefits                   | 5.3       | 5.6       | 6.3       | 7.2       | 8.5       | 9.2       | 8.8       | 64%                 | 61%                 |
| % of dependents receiving formal LTC in-kind and/or cash benefits             | 59.2      | 60.2      | 61.8      | 64.7      | 70.0      | 74.2      | 73.6      | 24%                 | 33%                 |
| <b>Composition of public expenditure and unit costs</b>                       |           |           |           |           |           |           |           |                     |                     |
| Public spending on formal LTC in-kind ( % of tot. publ. spending LTC)         | 47.8      | 47.0      | 45.9      | 46.8      | 47.2      | 46.8      | 46.6      | -3%                 | 5%                  |
| Public spending on LTC related cash benefits ( % of tot. publ. spending LTC)  | 52.2      | 53.0      | 54.1      | 53.2      | 52.8      | 53.2      | 53.4      | 2%                  | -27%                |
| Public spending on institutional care ( % of tot. publ. spending LTC in-kind) | 73.2      | 73.4      | 74.0      | 74.4      | 74.9      | 75.5      | 75.6      | 3%                  | 0%                  |
| Public spending on home care ( % of tot. publ. spending LTC in-kind)          | 26.8      | 26.6      | 26.0      | 25.6      | 25.1      | 24.5      | 24.4      | -9%                 | -1%                 |
| Unit costs of institutional care per recipient, as % of GDP per capita        | 53.5      | 53.3      | 53.9      | 58.1      | 61.2      | 62.3      | 62.6      | 17%                 | 10%                 |
| Unit costs of home care per recipient, as % of GDP per capita                 | 19.9      | 19.0      | 17.4      | 17.3      | 16.9      | 16.4      | 16.5      | -17%                | 1%                  |
| Unit costs of cash benefits per recipient, as % of GDP per capita             | 28.9      | 29.1      | 29.6      | 29.8      | 29.9      | 30.6      | 31.1      | 7%                  | -14%                |

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).